

Westview Health Clinic
3140 W Hayes
Clinton OK 73601
Telephone:580-323-1937 Fax: 580-323-1156

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date of Request : _____ Date Request Expires: Indefinite

TO: _____ (Name of individual or class of entities in possession of the Health Information)

I, _____ (Name of recipient or legally authorized representative)

Hereby consent to and authorize you to release to:

Kristy R Baker, ARNP (Agency requesting Health Information)

Copies of:

All Pertinent Medical Information

pertaining to the healthcare services that were provided to:

_____ (Name of recipient) _____ (Date of Birth)

during the following dates of treatment: Beginning of Treatment to Present Day

This authorization is given for the sole purpose of:

Transfer or Cooperation of Care

and will expire: (expiration date or event)

Upon Termination of Care

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it. To cancel this authorization, send a written request to Westview Health Clinic, Health Information, 3140 W Hayes, Clinton, OK 73601.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation, this authorization shall remain in full force and effect and shall not otherwise expire.

I understand that the information authorized for release may contain information which may be considered a communicable or venereal disease which may include, but is not limited to, diseases such as HEPATITIS, SYPHILIS, GONORRHEA, or the HUMAN IMMUNODEFICIENCY VIRUS (HIV), also known as ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

Date: _____

Signature of Recipient: _____

OR Signature of parent or representative: _____

Relationship to Recipient: _____